# New Hire Benefit Guide

*University Employees*

*Plan Year 2007 / 2008*

Benefit Services Division

Benefit Options

Choice. Value. Health.

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# INTRODUCTION

In this valuable reference guide, we have included explanations of the benefit programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This document is no longer just an enrollment guide, it is a resource to use throughout the year for services and benefits provided to you as a university employee. In this guide, you will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

**How to Use This Guide**

The Benefits Enrollment Guide is divided into chapters, each covering a specific benefit program or important information. These programs include:

- Employee Wellness
- Medical Plans
- Pharmacy Benefits
- Dental Plans
- Vision Plans
- Basic, Supplemental and Dependent Life Insurance
- Disability Plans
- Flexible Spending Accounts
- COBRA
- Additional Benefits

It is very important that you review this guide so you can fully understand the benefit programs offered to you through the State of Arizona and your university. This is your opportunity to select the coverage appropriate for both you and your qualified dependents.

You must make your initial enrollment selections within 31-days of your date of hire (or eligibility date for newly benefits-eligible employees). If you fail to enroll within the 31-day enrollment period, you waive your right to enroll in these plans until the next Open Enrollment or until you have a Qualified Life Event.

**During your initial benefits enrollment, you may take the following actions:**

- Elect or decline medical, dental and/or vision plan(s) for yourself and qualified dependents
- Elect or decline supplemental life insurance for yourself
- Elect or decline life insurance for your qualified dependents
- Elect or decline short-term disability (STD)
- Elect or decline to participate in the Flexible Spending Account (FSA) plans

**Enrollment Facts**

- New employees and newly benefits-eligible employees must enroll within 31 days of the date of hire/benefits eligibility.
- Medical, dental, vision, supplemental life, STD and Flexible Spending Account plans become effective on the first of the month following the date of enrollment.
- Basic life insurance and long-term disability are effective the date of hire/benefits eligibility.

*The Benefits Enrollment Guide is designed to provide an overview of the Benefit Options Program. The actual benefits available to you and the descriptions of these benefits are governed by the relevant summary plan descriptions and contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at any time.*

# IMPORTANT CONTACT INFORMATION

| Contact | Phone Number | Web Address | Policy Number |
|---|---|---|---|
| **Medical Plans** | | | |
| Fiserv Health - Harrington (for Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson) | 1.888.999.1459 | www.myazhealth.com | 3J |
| TDD/TTY | 1.866.503.3463 | | |
| UnitedHealthcare | 1.800.896.1067 | www.myuhc.com | 705963 |
| TDD/TTY | 1.888.697.9055 | | |
| Blue Cross Blue Shield (NAU only) | 1.800.423.6484 | www.bcbaz.com | Grp #0002 Active |
| **Pharmacy** | | | |
| Walgreens Health Initiatives | 1.866.722.2141 | www.mywhi.com | 512298 |
| **Dental Plans** | | | |
| Assurant | 1.800.443.2995 | www.assurantemployeebenefits.com | EA82 |
| Delta Dental | 1.800.352.6132 | www.deltadentalaz.com | 7777-0000 |
| Employers Dental Services | 1.800.722.9772 | www.mydentalplan.net | 6300 |
| MetLife Dental | 1.800.942.0854 | www.metlife.com/dental | 94739 |
| **Vision Plan** | | | |
| Avesis, Inc. | 1.800.828.9341 | www.avesis.com | 10790-1040 |
| **Flexible Spending Accounts** | | | |
| ASI | 1.800.659.3035 | email: asi@asiflex.com | |
| **Long Term Disability** | | | |
| Sedgwick CMS formerly (VPA) | 1.818.591.9444 | www.vpainc.com | |
| Standard Insurance Company | 1.866.440.4846 | www.standard.com/mybenefits/arizona/ | |
| **Life Insurance Plans** | | | |
| Standard Insurance Company | 1.866.440.4846 | www.standard.com/mybenefits/arizona/ | 617950 |
| Aetna Life Insurance | 1.800.523.5065 | www.aetna.com | |
| **Short Term Disability** | | | |
| Standard Insurance Company | 1.866.440.4846 | www.standard.com/mybenefits/arizona/ | |
| UnumProvident | 1.800.237.7736 | www.unumprovident.com | |
| **Travel Assistance** | | | |
| MEDEX | 1.800.527.0218 | www.standard.com/eforms/12092w.pdf | |
| **Other Important Numbers** | | | |
| Arizona State University<br>Tempe and Polytechnic campus employees<br>PO Box 875612<br>Tempe, AZ 85287-5612<br><br>West and Downtown Phoenix campus employees<br>PO Box 37100<br>Phoenix, AZ 85069 | | 1.480.965.2701<br>www.asu.edu/hr/benefits<br>email: askhr@asu.edu<br><br>1.602.543.8400<br>www.west.asu/hr/hr.html<br>email: benefitswest@asu.edu | |
| Northern Arizona University<br>PO Box 4113<br>Flagstaff, AZ 86011-4113 | | 1.928.523.2223<br>www.hr.nau.edu/<br>email: hr.contact@nau.edu | |
| The University of Arizona<br>888 N Euclid, Ste. 114<br>Tucson, AZ 85721 | | 1.520.621.3662<br>www.hr. Arizona.edu<br>email: benefits@email.arizona.edu | |
| ADOA Benefits Office<br>100 N 15th Ave #103<br>Phoenix, AZ 85007 | 1.602.542.5008<br>or<br>1.800.304.3687 | www.benefitoptions.az.gov<br>email: beneissues@azdoa.gov | |

Persons with a disability may request reasonable accommodation by contacting the Benefit Services Division.
If you need this information in an alternative format, please call 602.542.5008, option 2.

# EMPLOYEE WELLNESS

The benefits packages offered by all three state universities provide for the fact that you don't check your life at the door when you come to work. Family illnesses, finding care for an aging parent and relationship conflict are examples of how life can occasionally get out of balance with work.

Employee Assistance programs that are confidential and free are available to help employees sort things out, make changes and get referrals as needed. Worksite wellness programs can help employees reduce their risks for health problems and enhance their well-being. Governor Janet Napolitano has made employee wellness a priority for the State of Arizona.

**At Arizona State University**, Health Watch, the ASU Employee Wellness Program is designed to identify and deliver high quality, practical health education programs and screening services to promote and support ASU employees in establishing and maintaining healthy lifestyles. Screening services include cholesterol, diabetes, osteoporosis, skin cancer, thyroid, PSA, and mammography. All screenings include professional consultation and referrals if needed. Classes focus on nutrition, stress management, exercise and a variety of general health education topics. Additional activities include a flu prevention program, weight management program, and smoking cessation program.

The Work/Life Program at ASU is designed to be a strong, supportive culture for employees that is dynamic, flexible and respectful of the whole person. A sense of well-being crosses four domains of employees' lives: physical, mental, spiritual and emotional. When work/life programs can affect several or all of these in a positive manner, they contribute to healthier more productive employees. Program services include credit counseling/money management assistance, housing assistance, pre-paid legal services, and lawyer referral services. Discount coupons and tickets are available for over 50 attractions in Arizona, California, Florida, Texas, Colorado, Pennsylvania, and Virginia. In addition, over 150 businesses representing a wide range of goods and services extend ASU employees discounts.

**At The University of Arizona**, Life & Work Connections is a unique program that integrates Employee Assistance and Worksite Wellness together with Child Care and Family Resources, Elder Care and Life-Cycle Resources, and Work/Life Support. A variety of activities and educational presentations have been developed from a "whole-person, life-cycle" point of view to help employees make small lifestyle changes that increase resiliency and overall health and well-being.

Wellness screenings feature in-depth heart health risk assessment, diabetes, osteoporosis and skin cancer screenings all of which include on-site master's and Ph.D. level consultation and, if needed, referrals. A flu prevention program, weight management, nutrition and fitness consultations, a walking program, and smoking cessation program referrals are included also.

Department specific requests for a range of educational presentations on topics that cover health, family, professional and personal development can also be arranged. Our services can be viewed at *www.lifework.arizona.edu* and are offered not only to help you cope with emergencies, but also to help you plan for balance in your life and work.

**At Northern Arizona University**
The mission of the Employee Assistance & Wellness Office (EAW) is to provide opportunities for enhancing individual and organizational well-being to university faculty, staff and their families.

With today's complex lifestyles we all experience difficult times. The EAW office assists employees and their families with personal and professional issues, and helps to enhance overall health and wellness. A variety of wellness programs and workshops are offered each semester for NAU faculty and staff. Programs may also be coordinated on request from departments and groups.

The following services are provided by EAW:

- Short-Term Counseling
- Critical Incident Response
- Information and Referral
- Consultation
- Conflict Management
- Wellness at Work Program providing flu vaccines and health screenings
- Wellness Workshop Series

**Who may use Employee Assistance & Wellness (EAW)?**
Counseling services may be used by all benefit-eligible employees and their covered family members. All other services (e.g., wellness programs) may be used by all employees and their family members unless otherwise noted.

You can obtain more information about EAW by accessing their website at *www4.nau.edu/eaw/*.

The EAW office is located at 415 South Beaver Street, Flagstaff, AZ 86001. You can contact them by phone at 1.928.523.1552 or by email at Ask-EAW@nau.edu.

# ELIGIBILITY

**Eligible Employees**
University employees regularly scheduled to work 20 hours or more per week for six months or longer (except those listed below as ineligible) and their qualified dependents may participate in the Benefit Options and University Benefits Programs and FSA plans, provided they comply with the contractual requirements of their selected plans.

**Ineligible Employees**
- Employees who work less than 20 hours per week
- Employees in seasonal, temporary or emergency positions
- Employees in university graduate assistant/ associate positions
- Patients or inmates employed in state institutions
- Non-State employee officers and enlisted personnel of the National Guard of Arizona
- Employees in positions established for rehabilitation purposes

**Eligible Dependents**
The following dependents may be enrolled in your benefit plans, however, proper documentation may be required.
- Your legal spouse
- Natural, adopted and/or stepchildren unmarried and under age 19, or under 25 if a full-time student at an accredited educational institution
- Minors under the age of 19 for whom the employee-member has court-ordered guardianship
- Foster children under the age of 19
- Children placed in the employee's home by court order pending adoption
- Natural, adopted and/or stepchildren who were disabled prior to age 19

Please note: If your dependent child is approaching age 19 and is disabled, application for such continuation of dependent status must be made with your Human Resources Office within 31 days of the child's 19th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration guidelines, that occurred prior to his or her 19th birthday. Final eligibility will be determined by the Plan Administrator and documentation may be required periodically to continue a dependent on your plan. See Plan Description for "full-time student" information.

**Dependent Documentation Requirements**
If you are enrolling a spouse or dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation, such as a marriage license for a spouse or a birth certificate or court order for dependents, is provided to your Human Resources Office. If your dependent is a full-time student over the age of 19, your insurance carrier will request a copy of the dependent's class schedule.

**Qualified Medical Child Support Order (QMCSO)**
If a QMCSO exists, you must elect coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO.

**If You and Your Spouse are State Employees**
If both you and your spouse are eligible State of Arizona employees, be sure to take into account the coverage that you each can elect. If it is determined there is dual coverage, you will be responsible for coordination of benefits for any claims paid under your dependent status. Health insurance premiums will not be reimbursed to either employee as a result of dual coverage.

**Other Important Information**

**ID Cards**
ID cards for your medical, dental and vision plans will arrive separately and are sent directly from the vendor to your home address. Typically, ID cards arrive seven to fourteen business days after your benefits become effective.

- MetLife Dental does not issue ID cards.
- Contact the vendor directly if you do not receive your cards or if you need additional or replacement cards.
- UnitedHealthcare, Delta Dental and Avesis allow members to print temporary ID cards from their website. This may be helpful if you need services before you receive your cards.

**Pretax Benefits**
Because monthly insurance premiums are paid on a pretax basis, federal regulations restrict the enrollment status changes that you can make during the plan year to the following times:

Federal regulations restrict the enrollment status changes that you can make during the plan year when your monthly insurance premiums are paid on a pretax basis to the following times:

- Annual Open Enrollment
- Qualified Life Events

The employee benefits that are eligible for pretax premium payments are:

- Medical insurance
- Dental insurance
- Vision insurance
- Employee life insurance up to $35,000
- Flexible Spending Accounts

**After-Tax Benefits**
Plans paid for with after-tax premiums do not have the same restrictions during the plan year. You can reduce or cancel after-tax plans without a Qualified Life Event. However, midyear

enrollment can only occur in conjunction with an appropriate Qualified Life Event provided the request is made within 31 days of the event.

**Examples of plans with after-tax premiums are:**

- Short-Term Disability
- Life insurance over $35,000
- Dependent life insurance

**Changing Your Benefits**

You may only change your benefit elections during the year if you experience a Qualified Life Event (QLE).

Qualifying Life Events include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse
- Changes in dependent status: birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, or student status
- Changes in your employment status or work schedule that affect benefits eligibility
- Changes in your spouse's benefits coverage or eligibility
- Changes in a permanent residence that result in different available plan options..

Please consult with your Human Resources Office to determine whether or not the life event you are experiencing qualifies under the regulations, for the effective date for the change and for the documentation required to process the change.

**Timeframe to Submit a Change Request**

Requested benefit changes must be submitted to your Human Resources Office within 31 calendar days of the event. Failure to request a change within 31 days will result in the denial of benefit changes until the next QLE or annual Open Enrollment.

**Effective Date of the Change**

Consult with your Human Resources Office to determine whether or not the life event you are experiencing qualifies under the regulations, for the effective date of the change and for the documentation you are required to submit.

# MEDICAL PLAN FEATURES

**What is an "EPO" plan and how is this different from a "PPO" plan?**
An EPO is an Exclusive Provider Organization; you must obtain services from a contracted network provider and your cost is a minimal co-pay. A PPO plan is a Preferred Provider Organization that allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a plan year deductible and pay a percentage of all covered services.

**The State offers "open access" in all of the EPO plans. What does this mean?**
Open access refers to how you "access" physicians. You may schedule an appointment directly with any physician of your choosing without a referral. The provider MUST be contracted within your network.

**If one of my doctors refers me to a specialist or medical provider that is NOT within my EPO network, am I responsible for the medical charges?**
Yes. In the EPO plan, all medical services received must be with contracted network medical providers.

If your PCP has scheduled an appointment for x-rays, laboratory tests, or specialists, you must make sure they are within your medical network.

If you are enrolled in the PPO plan, you may obtain out-of-network services and pay 30 percent of the covered charges, after you have met your deductible.

**How do I find out what is covered in the health plan?**
Covered benefits are detailed in a Plan Description. A plan description outlines your health insurance coverage and provides information on how claims will be paid, services that require pre-certification, services that are covered and items that are excluded by the health plan. You will receive a copy of the plan description after the beginning of a new plan year. You may also view these descriptions online at *www.benefitoptions.az.gov*.

**What is a network service area?**
A network service area is the region in which your network is offered and is based on your primary residential address:

- The RAN+AMN EPO plan is offered statewide.
- The Schaller Anderson EPO plan is offered statewide.
- The UnitedHealthcare EPO and PPO plans are offered in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties.
- The Arizona Foundation PPO plan is offered statewide.
- The Beech Street PPO plan is offered for members living outside of Arizona and will be used as a national travel network if you are enrolled with Arizona Foundation, RAN+AMN, or Schaller Anderson.

**What is a Plan Administrator?**
A Plan Administrator is the contracted organization that processes the medical claims, provides customer service and runs the day-to-day operations of the health plan:

- If you are enrolled with Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson, your Plan Administrator is Fiserv Health - Harrington
- If you are enrolled with UnitedHealthcare, your Plan Administrator is UnitedHealthcare.
- If you are enrolled in the NAU only BCBS PPO, your Plan Administrator is BCBS.
- The ADOA Benefits Office is the Plan Sponsor not the Plan Administrator.

**I've heard the terms "integrated" and "non-integrated." What do they mean?**
Integrated and non-integrated describe the way services are provided in each health plan:

- If you are enrolled with Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson, you are in the non-integrated plan. This means multiple organizations supply the health plan services:
- Arizona Foundation, Beech Street, RAN+AMN and Schaller Anderson provide the networks of hospitals and medical providers.
- Fiserv Health - Harrington provides the claims payment processes, day-to-day operations, and customer service.
- Schaller Anderson provides prior authorization, disease management, and medical review services.
- If you are enrolled with the integrated plan, UnitedHealthcare provides the following: hospital and provider networks, claims payment processes, day-to-day operations, prior authorization, and disease management services.
- Walgreens Health Initiatives (WHI) is a Pharmacy Benefit Manager and provides pharmacy services for both the integrated and non-integrated health plans.

**What is a Pharmacy Benefit Manager (PBM)?**
A PBM provides the national network of pharmacies, mail order service, and specialty pharmacy services. A PBM manages pharmacy benefits in the following ways: by providing bulk discounts on medications through the use of a formulary, by reviewing the way medications are used by members, and by implementing targeted programs to reduce overall pharmacy costs. These programs promote the use of cost-effective medications, maximize generic efficiency, and encourage proper utilization. A PBM also works with physicians to review medications prescribed and look for possible lower cost alternatives.

**I have been contacted by someone and asked if I want to participate in a disease management program. What is disease management?**
Disease Management is a voluntary service provided by Schaller Anderson or UnitedHealthcare to ASU and UA employees and by BlueCross BlueShield to NAU employees that assists members with treatment needs for chronic conditions. If you are being treated for any of the conditions listed below, you may be contacted by the Disease Management staff with further information on the program. This is a free service to provide you information, assistance, and resources to manage the following conditions:

- Asthma
- Congestive Heart Failure
- Diabetes
- Coronary Artery Disease

**What is Perinatal care? What services are available to me if I am pregnant or planning to become pregnant?**
If you are pregnant, or planning to become pregnant, you can receive care and education through the Benefit Options Perinatal Program. This program helps future mothers and their newborns get a healthy start even before pregnancy begins. Resources available include:

- Preconception counseling
- Educational materials on common topics
- Screening and health assessment to help identify high risk pregnancies
- Special management of medical care by health professionals for expecting mothers with high risk pregnancies

Contact your Plan Administrator for more information on participation in these programs.

**What is Coordination of Benefits?**
When an employee is covered by more than one health plan, benefits are coordinated so that no more than 100 percent of the claim is paid to a medical provider. One plan will be considered primary and the other will be considered secondary. For additional information on how coordination of benefits will be applied, please refer to the appropriate Plan Description.

**What is Transition of Care?**
If you are a new employee and/or changing from Arizona Foundation, Beech Street, RAN/AMN, or Schaller Anderson to UnitedHealthcare (or from UnitedHealthcare), to other state offered coverage you may continue an active course of treatment with your health care provider and receive in-network benefits during the pre-approved transition period, if one of the following applies:

1. You have a life threatening disease or condition;
2. If you have been receiving care, and a continued course of covered treatment is Medically Necessary, you may be eligible to receive "transitional care" from the non-Participating Provider;
3. You have entered the third trimester of pregnancy on the effective date of enrollment; or
4. If you are in your second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies and procedures and quality assurance requirements.

There may additional circumstances where continued care by a provider no longer participating in the network will not be available, such as when the provider loses his license to practice or retires. You may obtain a copy of the Transition of Care form at *www.benefitoptions.gov*.

# ONLINE FEATURES OF MEDICAL PLAN INFORMATION

Members can now review their personal profiles, view the status of medical claims, obtain general medical information, and learn how to manage their own healthcare through the available health plan websites.

**Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson Healthcare**
Members enrolled with any of the networks above may view the following information on *www.myazhealth.com* (you will need to register with a user name and password):

- **Personal Profile** Check your eligibility status and personal profile.
- **Claims Inquiry** View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
- **Deductible Status** View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
- **Secure Mail** With the "Secure Mail" feature, you may ask questions anytime day or night. You will receive replies about your confidential health benefit information within 3 business days without the worry of transmitting your personal information over the internet.
- **Health Information** Compare hospitals based on quality of care, procedures and patient safety measures. You may also view a medical encyclopedia, information on general health topics, and an outline of questions you should ask your doctor.
- **Medline Plus** Medline Plus provides extensive health information on over 650 diseases and conditions; offers a medical dictionary and encyclopedia; contains information on clinical health trials; and features the latest medical research in medicine.
- **Provider Search** You may click on your network to research contracted network physicians, hospitals, and medical providers.
- **Provider Information** You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure e-mail feature.
- **Claim Forms** You may download claim forms and information to submit claims for medical services and reimbursement for out-of-pocket expenses.

**UnitedHealthcare**

Members enrolled in UnitedHealthcare you can view the following information on *www.myuhc.com* (you will need to register with a user name and password):

- **Personal Profile** Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime
- **Provider Search** Find the physicians and hospitals that are convenient and right for you.
- **Provider Information** You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
- **Claims Inquiry** View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
- **Deductible Status** View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
- **Hospital Comparison** Compare hospitals based on quality of care, procedures, and patient safety measures with the Hospital Comparison tool.
- **Treatment Cost** Find out and compare what different treatments will cost using the Treatment Cost Estimator, before you need to make a decision.
- **Health Information** Look up a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and Best Treatments organizations.
- **Nurseline** Chat online with registered nurses 7 days a week for trusted information and peace of mind when you have a question or during times when you cannot reach your doctor.
- **Expert Information** Participate in monthly online events with leading experts in health care.

***BCBS (NAU only):*** *Members can access BlueNet, BlueCross BlueShield of Arizona's online member website at the following address:* www.bcbsaz.com.

# MEDICAL PLANS COMPARISON CHART

| | EPOs | PPOs | |
|---|---|---|---|
| These plans are available to employees statewide | RAN+AMN EPO<br>Schaller Anderson Healthcare EPO | Arizona Foundation Medical Care PPO | |
| In addition to the plans above, the following plans are offered to employees in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties | UnitedHealthcare EPO | UnitedHealthcare PPO | |
| This plan is available to employees living out of state. | | Beech Street PPO | |
| **DEDUCTIBLE/MAXIMUMS** | **In-Network Co-Pay** | **In-Network Co-Pay** | **Out-of-Network Out-of-Pocket** |
| **PCP REQUIRED FOR EACH MEMBER?** | NO | NO | NO |
| **PCP REFERRAL REQUIRED TO SEE A SPECIALIST?** | NO | NO | NO |
| **PLAN YEAR DEDUCTIBLES** INDIVIDUAL<br>EMPLOYEE + ONE / FAMILY | $0<br>$0 | $0<br>$0 | $300<br>$600 |
| **OUT-OF-POCKET MAXIMUMS** INDIVIDUAL<br>EMPLOYEE + ONE / FAMILY | $0<br>$0 | $1,000<br>$2,000 | $3,000<br>$6,000 |
| **LIFETIME MAXIMUMS** | $0 | $0 | $2,000,000 |
| **PHYSICIAN SERVICES**<br>Office Visits/consultations | $10<br>Max of 1<br>co-pay/day/provider | $10<br>Max of 1<br>co-pay/day/provider | 30%*<br>After Deductible |
| ***SPECIALIST VISITS (new co-pay)*** | *$20* | *$20* | *30%*<br>*After Deductible* |
| **PREVENTATIVE CARE**<br>Well Baby, Child and Adult Physical Exams,<br>Annual Well-Women Exams (GYN visit & PAP smear test)<br>Annual Well-Man Exams (Office Visit & PSA blood test),<br>Adult Immunizations (e.g., pneumonia, flu) | $10 | $10 | 30%*<br>After Deductible |
| **MAMMOGRAPHY SCREENING**<br>(Coverage based on patient age or threat) | $0 | $0 | 30%*<br>After Deductible |
| **OUTPATIENT SERVICES**<br>Freestanding ambulatory facility or hospital outpatient surgical center | $0 | $0 | 30%*<br>After Deductible |
| **HOSPITALIZATION SERVICES**<br>Room & Board (private room when medically necessary) | $0 | $0 | 30%*<br>After Deductible |
| Intensive Care | $0 | $0 | 30%*<br>After Deductible |
| Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologist | $0 | $0 | 30%*<br>After Deductible |
| **EMERGENCY CARE**<br>Urgent Center Care | $20 | $20 | 30%*<br>After Deductible |
| *Emergency room (new co-pay)* | *$125, waived if admitted* | *$125, waived if admitted* | *$125, waived if admitted* |
| Ambulance (for medical emergency or required interfacility transport) | $0 | $0 | Emergency paid at in-network benefit rate |
| **CHIROPRACTIC** | $10 | $10 | 30%*<br>After Deductible |
| **PRE-EXISTING CONDITIONS** | COVERED | COVERED | COVERED |
| **DURABLE MEDICAL EQUIPMENT** | $0 | $0 | 30%*<br>After Deductible |
| **BEHAVIORAL HEALTH** | | | |
| Outpatient | $10 | $10 | $10 |
| Inpatient | $0 | $0 | 30%*<br>After Deductible |

*Percentages paid based on Reasonable and Customary Charges. This is a Summary only; please see Plan Descriptions for detailed provisions. If there is any discrepancy between this information and the official documents, the official documents will always govern. The State of Arizona and University of Arizona reserve the right to change or terminate any of its plans, in whole or in part, at any time.*

# PHARMACY PLAN FEATURES

**Is there a separate enrollment process for the pharmacy benefit?**
If you elect any Benefit Options medical plan, Walgreens Health Initiatives (WHI) will be the network you use for pharmacy benefits. Enrollment is automatic when you enroll in a medical plan, and there is no separate cost.

**How does the plan work?**
The WHI network consists of more than 62,000 participating chain and independent pharmacies nationwide, with 1,000 member pharmacies in Arizona. All prescriptions must be filled at a network pharmacy or through the mail order service. The cost of prescriptions filled out-of-network will not be reimbursed. To find a pharmacy near your home, work address, out-of-town vacation address, or your dependent student's out-of-state address, refer to *www.mywhi.com*.

Multilingual customer service representatives are available 24 hours a day, 7 days a week at 1.866.722.2141 to assist you.

The WHI plan has a three-tier formulary; the cost for up to a 30-day supply of medication bought at a retail pharmacy is $10 for a generic drug, $20 for a preferred (formulary) drug, and $40 for a non-preferred (non-formulary) drug. You can find information on WHI's formulary and look up the cost for specific drugs at *www.mywhi.com*.

The Walgreens Health Initiatives Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are generics and brand names available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly and as needed throughout the year to add significant new medications as they become available.

Medications that no longer offer the best therapeutic value for the plan are deleted from the PML once a year, and a letter is sent to any member affected by the change. To see what medications are on the PML, log on to *www.mywhi.com* or contact the WHI Customer Care Center to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the medications you need which saves money for you and your plan.

**What is the "mail order service" and how do I take advantage of it?**
A convenient and less expensive mail order service is available for employees who require medications for on-going health conditions, or who will be in an area with no participating retail pharmacy for an extended period of time. Here are a few guidelines and benefits when using the mail order service:

- You must submit a written 90-day prescription from your physician for any new mail order drug.

- You may request up to a 90-day supply of medication for two co-pays.
- You may fill a 12 month supply of medication with prior authorization.
- You may pay by check or charge your co-pay to a Visa, MasterCard, American Express, or Discover account.
- You may register your email address to receive information on your orders.
- You can order refills online at *www.mywhi.com* or via phone at 1.866.722.2125.
- One-on-one consultations with a licensed pharmacist are also available at this number.

**Clinical Prior Authorization**
Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by you, your local pharmacy, or your physician by calling WHI at 1.877.665.6609, Monday through Friday, 8:00 a.m. to 8:00 p.m.

**Specialty Pharmacy Program**
Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Specialty Pharmacy. This program assists you with monitoring your medication needs for certain conditions and by providing patient education. The Specialty Pharmacy Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage, handling, and delivery. Call Walgreens Specialty Pharmacy at 1.888.782.8443 for further information on this program.

The Specialty Pharmacy program includes but is not limited to the following conditions::
- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or via the mail order service. Call WHI at 1.888.782.8443 for further information on this program. Medications for these conditions through the Specialty Pharmacy Program include, but are not limited to:
- Anabolic Steroids – Injectable (Deca-Durabolin®, Virilon IM®);
- Anabolic Steroids - Oral (Anadrol-50®, Android Testred®, Oxandrin®, Winstrol®);
- Anabolic Steroids – Topical (Androderm®, Androgel®, Testoderm®);
- Botulinum Toxins (Myobloc®, Botox®);

A Specialty Care Representative may contact you to facilitate your enrollment in the WHI Specialty Pharmacy Program. Trained Specialty Care pharmacy staff are available 24 hours a day, 7 days a week, to assist you. You may also enroll directly into the program by calling 1.888.782.8443.

**Non-Covered Drugs**
Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your

**NAU Only BlueCross BlueShield Pharmacy Plan**
There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic ($7), preferred brand ($20), non-preferred brand A ($40) or non-preferred brand B ($80) co-payment. Drugs may change cost-sharing levels without notice. The BCBSAZ Prescription Medication Guide can be used to determine your co-payment and can be found on the BCBS website at *www.bcbsaz.com/pharmacy* or call 1.800.345.1985.

A mail order benefit is available through Walgreen's mail order service. You may receive up to a 90-day supply of maintenance prescription for one co-payment. The co-payment for a 90-day mail order supply is the same as the co-payment for a 30-day supply through a pharmacy.

More complete information on your prescription drug benefit can be found in the BCBS benefit plan booklet at *www.hr.nau.edu*. Go to Benefits, Health, BCBS Plan Book.

# ONLINE FEATURES OF PHARMACY PLAN INFORMATION

**Walgreens Health Initiatives (WHI)**
All members enrolled in Arizona Foundation, RAN+AMN, Schaller Anderson and UnitedHealthcare can view pharmacy information by registering at www.mywhi.com:

- **Co-pay and Drug Information** — You may research your medication to learn what co-pay is required at retail or through mail-order service.
- **Eligibility Information** — Check your eligibility status for you and your family members.
- **Search the Formulary** — You may research medications to determine whether they are generic, preferred or non-preferred drugs. This classification will determine which co-pay is required.
- **Download the Formulary** — You may print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.
- **Locate a Nearby Pharmacy** — You may view pharmacies in your area by ZIP code or city.
- **Prescription History** — You may view your entire prescription history, including all of the medications received by each member.
- **Mail Service Forms** — You may register for mail-order service by downloading the registration form and following the step-by-step instructions.
- **Refill Information** — You may review refill information, including when your next refill can be ordered and available options to request your next refill.
- **Drug Information** — You may research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
- **Product News** — The latest product news is available including drug recalls and industry advances in the pharmaceutical industry.

NAU only: BCBS members can access BlueNet, BlueCross BlueShield of Arizona's online member website at the following address: *www.bcbsaz.com/.* Information on the pharmacy plan and co-payment levels for prescriptions can be found at www.bcbsaz.com/pharmacy; go to 4-level prescription drug benefit.

# DENTAL PLAN FEATURES

Following is a brief description of the dental plans available through Benefit Options. For a complete listing of covered services for each plan, please refer to the plan description located on the website, www.Benefitoptions.az.gov. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your co-payment.

**What plans are available for me to choose from?**
Employees may choose between two plan types. They are the Prepaid and the Preferred Provider Organization (PPO) plans.

**Prepaid Plans**

- You must see a Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums.
- No claim forms.
- No waiting periods.
- Pre-existing conditions are covered.
- Set co-payments for services provided by your general dentist.

*Employers Dental Services (EDS)*
You must choose one dentist for your family from a network of participating dentists. You can change your dentist at any time by contacting EDS or by using the "change my dentist" function on the website *www.mydentalplan.net*. Members can self refer to Specialists within the network. Specialty services are provided at up to a 25% discount off the Specialist's normal fees. Separate lab fees apply to some services as indicated in the schedule of benefits.

*Assurant Employee Benefits*
Each family member can choose a different dentist. You can self refer to a Specialty Benefit Amendment (SBA) Specialist in the Network who accepts a co-pay for most common procedures, listed under the SBA. If a procedure is not listed in the SBA co-pay schedule or the Specialist does not participate in the SBA, you will receive a discount off the Specialist's normal retail charges. This discount also includes Orthodontic Services.

**Indemnity/PPO Plans**

- You may see ANY licensed dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services.
- There is a maximum lifetime benefit of $1,500 per person for orthodontia.
- You may need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

*Delta Dental*

Over 80 percent of Arizona's licensed dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or co-payments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels.

*MetLife Dental*

MetLife participating dental providers accept negotiated fees as payment in full after your deductibles and co-payments are met. These fees are typically 15 to 30 percent below average rates. Non-covered services provided by a participating dentist are also charged at a lower rate. Covered expenses from a non-participating dentist are paid according to established reasonable and customary charges.

# Dental Plans Comparison Chart

| | Employers Dental Services | Assurant Employee Benefits | Delta Dental | MetLife Dental |
|---|---|---|---|---|
| **PLAN TYPE** | Prepaid | Prepaid | Indemnity/PPO | Indemnity/PPO |
| **DEDUCTIBLES** | None | None | $50/$150 | $50/$150 |
| **PREVENTIVE CARE** | Co-Pay | Co-Pay | Co-Insurance | Co-Insurance |
| Office Visit | $5 | *$10* | $0<br>Deductible Waived* | $0<br>Deductible Waived* |
| Oral Exam | $0 | $0 | $0<br>Deductible Waived | $0<br>Deductible Waived |
| Prophylaxis/Cleaning | *$7* | *$5* | $0<br>Deductible Waived | $0<br>Deductible Waived |
| Fluoride Treatment (to age 19) | $0 | $0 | $0<br>Deductible Waived | $0<br>Deductible Waived |
| X-Rays | $0 | $0 | $0<br>Deductible Waived | $0<br>Deductible Waived |
| **BASIC RESTORATIVE** | Co-Pay | Co-Pay | Co-Insurance | Co-Insurance |
| Office Visit | $5 | *$10* | 20%* | 20%* |
| Sealant (to age 19) | $12/tooth | *$15/tooth* | 20% | 20% |
| Filings | *$13-$30 (amalgam)* | *$20-$45 (amalgam)* | 20% | 20% |
| Extractions | *$55 (single)* | *$20 (single)* | 20% | 20% |
| Periodontal Gingivectomy | *$225 Per Quadrant* | *$150 Per Quadrant* | 20% | 20% |
| Oral Surgery | *$55-$120* | *$20-$135* | 20% | 20% |
| **MAJOR RESTORATIVE** | | | | |
| Office Visit | $5 | *$10* | 50%* | 50%* |
| Crowns | *$280 + Lab* | *$265 + Lab* | 50% | 50% |
| Dentures | *$325 + Lab* | *$365 + Lab* | 50% | 50% |
| Fixed Bridgework | *$280+ Lab* | *$305 + Lab* | 50% | 50% |
| Crown/Bridge Repair | *$5 + Lab* | *$25* | 50% | 50% |
| Inlays | *$135-$170* | *$230-$305 + Lab* | 50% | 50% |
| **ORTHODONTIA** | | | | |
| Child | 25% discount of Plan Specialist normal retail | 25% discount of Plan Specialist normal retail | 50% | 50% |
| Adult | 25% discount of Plan Specialist normal retail | 25% discount of Plan Specialist normal retail | 50% | 50% |
| **TMJ Services** | | | | |
| Exam, services, etc. | Up to 25% of normal fees | Up to 25% of normal fees | No coverage | No coverage |
| **MAXIMUM BENEFITS** | | | | |
| Annual combined preventive, basic, and major services | No dollar limit | No dollar limit | $2,000/person | $2,000/person |
| Orthodontia Lifetime | No dollar limit | No dollar limit | $1,500/person | $1,500/person |

*This is a Summary only; please see Plan Descriptions for detailed provisions.*

**Office visit and exams of any type are covered only two times a year at 100%.*

*If there is any discrepancy between this information and the official documents, the official documents will always govern. The State of Arizona and University of Arizona reserve the right to change or terminate any of its plans, in whole or in part, at any time.*

# VISION PLAN FEATURES

Coverage for vision examinations and corrective eyewear is available to all benefits-eligible employees and their qualified dependents through Avesis, Inc. Employees are responsible for the full premium cost of this voluntary plan.

You may receive services from either a participating or a non-participating provider once a plan year; exceptions are the Lasik benefit which is available one time only and the additional eyewear benefit which you may use as many times as you wish.

To find a participating provider, either go online at *www.avesis.com* or call 800.828.9341, call the provider and identify yourself as an Avesis member and schedule your appointment.

If services are received from a non-participating provider, you will pay the provider at the time of service and submit a claim to Avesis for reimbursement. The claim must be filed within three months from the date of service and include your name, member ID number and mailing address, the patient's name and date of birth, the group name and number, and an itemized statement of services.

| Participating Provider Fee Schedule | Co-pay | Allowance Given to Employee |
|---|---|---|
| 1) Vision examination and **one** of the following: | $10 | |
| a) Single, bifocal, trifocal, or lenticular lenses and frame | | $100 - $150 allowance |
| b) Contact Lens* | | $130 allowance |
| c) LASIK Surgery | | $150 allowance |
| 2) Options (E.g. Progressive lens, tinting, coatings, transitional lens) | | 20% discount from provider's fee |

* Contact lenses would be covered in full if considered medically necessary.

**Non-participating Provider**

If services are received from a non-participating provider, you will pay the provider at the time of service and submit a claim to Avesis for reimbursement. The claim must be filed within three months from the date of service and include your name, member ID number and mailing address, the patient's name and date of birth, the group name and number, and an itemized statement of services. An out-of-network reimbursement form is available by visiting the Avesis website at *www.avesis.com*.

| Non-Participating Provider Fee Schedule | Employee is Reimbursed |
|---|---|
| Vision Examination | Up to $50 |
| Single Vision Lenses | Up to $30 |
| Bifocal Lenses | Up to $45 |
| Trifocal Lenses | Up to $55 |
| Lenticular Lenses | Up to $110 |
| Progressive Lenses | Up to $45 |
| Frames | Up to $50 |
| Options (e.g. tinting, coatings) | No reimbursement |
| Contact Lens Benefit* | |
| Elective | $150 |
| Medically Necessary | $300 |
| LASIK Surgery | Not Covered |

*Member may choose to receive one of the following within their plan period: spectacle lenses and a frame, OR the contact lens benefit. The Contact Lens Benefit takes the place of the exam, lenses and frame within that plan period.

This is a brief description of your voluntary vision care plan available through Benefit Options. For a complete listing of covered services for this plan, please refer to the plan description located on the website, *www.benefitoptions.az.gov* or contact Avesis directly at 1.800.828.9341.

# ARIZONA, NATIONAL AND INTERNATIONAL COVERAGE

**(Medical, Dental, and Vision)**

| | Within Arizona | Within U.S. | International |
|---|---|---|---|
| **MEDICAL** | | | |
| **EPO Plans** | | | |
| RAN+AMN | Covered in-network | Covered using Beech Street Provider | Emergency and Urgent Only |
| Schaller Anderson Healthcare | Covered in-network | Covered using Beech Street Provider | Emergency and Urgent Only |
| UnitedHealthcare | Covered in-network | Covered using UHC EPO provider network | Emergency and Urgent Only |
| **PPO Plans** | | | |
| Arizona Foundation | Covered in/out-network | Covered using AZF PPO in/out-network or Beech Street Provider | Emergency and Urgent Only |
| Beech Street | Covered in/out-network | Covered in/out-network | Emergency and Urgent Only |
| UnitedHealthcare | Covered in/out-network | Covered using the UHC PPO in/out provider network | Emergency and Urgent Only |
| **NAU Only** | | | |
| BlueCrossBlueShield PPO | | Outside AZ: Covered as in-network *only* if you receive covered services from a provider who participates as a PPO provider with the local BCBS plan. For assistance in locating a local BCBS network provider in another state, call 1.800.810.2583. | For assistance with locating a provider and submitting claims, call 1.800.810.2583 or 1.804.673.1686. For an international claim form, go to www.bcbs.com/bluecardworldwide/index.html |
| **PHARMACY** | | | |
| Walgreens Health Initiatives | Covered in-network | Covered in-network | Not Covered |
| **DENTAL** | | | |
| **Prepaid Plans** | | | |
| Assurant Employee Benefits | Covered in-network | Emergency Only | Emergency Only |
| EDS | Covered in-network | Emergency Only | Emergency Only |
| **PPO Plans** | | | |
| Delta Dental | Covered in/out-network | Covered in/out-network | Covered out-of-network |
| MetLife Dental | Covered in/out-network | Covered in/out-network | Covered out-of-network |
| **VISION** | | | |
| Avesis | Covered in-network | Covered out-of-network | Covered out-of-network |

Note: Treatment will be subject to the Plan Description.

# NATIONAL AND INTERNATIONAL TRAVEL ASSISTANCE

Services are provided to you and your dependents traveling at least 100 miles from your residence for a maximum period of 90 days.

All state employees eligible or the Life Insurance, their spouses, and unmarried dependents under age 19 (or under 25 if a full-time student at an accredited educational institution) are able to use this service.

**Pre-Trip Assistance**

- Consulate and embassy locations
- Currency exchange information
- Health hazards advice and inoculation requirements
- Passport and visa information
- Weather information
- Hotel and airport locator service

**Medical Assistance**

- Locating medical care
- Assist in communications with medical providers
- Provide translation and interpreter services 24/7 if you are outside of the United States
- Hotel convalescence arrangements
- Medical insurance coordination for medical care
- Prescription drug assistance to obtain emergency or needed medications

**Emergency Transportation Services**

Services are covered up to a combined single limit of $150,000.

- Related medical services, medical supplies, and a medical escort are covered when applicable and necessary:
- Repatriation if it is medically necessary after initial treatment and stabilization. Family or friend travel arrangements if you are hospitalized for more than 7 days and are traveling alone. MEDEX will provide round-trip economy airfare for one family member or friend to the location of your hospital.
- Return of dependent children if you are hospitalized for more than 7 days - to coordinate the return of a dependent back to the United States. MEDEX will provide one-way economy airfare for children under age 18 to their permanent residence, including an escort for children, if necessary.
- Vehicle return if you require emergency evacuation or repatriation

**Travel Assistance Services**

- Emergency credit card and ticket replacement for lost, stolen, or damaged cards or tickets

- Emergency passport and document replacement for lost, stolen, or damaged passports or travel documentation
- Emergency cash and payment assistance
- Emergency message service to relay information to family members
- Missing luggage assistance
- Location of legal assistance
- Bail bond services

**Personal Security Services**
MEDEX provides real-time security intelligence in the event you feel you are threatened due to political unrest, social instability, weather conditions, health or environmental hazards.

**How to Access Services**
Contact MEDEX at 1.800.527.0218. To read more about the program and print a travel assist ID card, go to *www.standard.com/eforms/12092w.pdf*. The Group Number for the State of Arizona is 7088.

# LIFE INSURANCE BENEFITS

**STANDARD LIFE INSURANCE**

***Basic Life Insurance and AD&D***

You are automatically covered for $15,000 of basic life insurance provided through Standard Insurance Company at no cost to you. The State also pays for an additional $15,000 of Accidental Death and Dismemberment (AD&D) insurance coverage. A $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. You are automatically covered in these three programs. No enrollment is necessary.

***Supplemental Life Insurance and AD&D***

Supplemental life insurance coverage is available to employees who would like additional life insurance beyond what the State provides. Your cost is based on your age as of October 1 (the first day of the plan year). The maximum amount of supplemental life insurance that you can elect through the State's group plan is three times your annual base salary, or $300,000, whichever is less. Your employee supplemental AD&D coverage is the same as the supplemental life amount that you elect.

When electing or changing supplemental life after your initial enrollment, you may increase or decrease your supplemental life coverage. You may increase in multiples of $5,000 up to a maximum $20,000 per year. You may also decrease your coverage in multiples of $5,000 or cancel your coverage. Supplemental life coverage above $35,000 is paid on an after-tax basis, and may be cancelled at any time.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. It is important to keep your beneficiary information current. You may change your beneficiary using the web enrollment system during Open Enrollment. Remember: Adding a beneficiary does not automatically delete a previously-designated beneficiary. If you wish to change a previously designated beneficiary, you must actively do so while enrolling via the website.

***Dependent Life Insurance***

You may purchase life insurance coverage for your spouse and/or dependents in the amount of $2,000, $4,000, $6,000, $12,000, or $15,000. You do not have to elect Supplemental coverage from The Standard for yourself in order to choose this dependent plan. Each person will be covered for the amount you choose for a small monthly premium. In the event of a claim, you are automatically the beneficiary.

**AETNA SUPPLEMENTAL LIFE INSURANCE***

***Arizona State University and Arizona Board of Regents***

You pay all premiums for the Aetna life insurance coverage amount that you elect. You may apply for coverage in increments of one, two, or three times your annual salary rounded up to the nearest $1,000. The maximum you may apply for is three times your annual salary or $100,000, whichever is less. Dependent life insurance coverage for your spouse in the amount of $5,000 and for your children in the amount of $2,500 is automatically included. During your initial new hire/eligibility enrollment, you may elect up to the maximum coverage available to you. Thereafter, changes in coverage are restricted to one level increase during Open Enrollment and are subject to proof of insurability and approval by Aetna. Coverage levels automatically adjust for changes to your age and salary.

***The University of Arizona***

You pay all premiums for the Aetna life insurance coverage amount that you elect. You may apply for coverage in increments of one, two, or three times your annualized salary rounded up to the nearest $1,000. The maximum you may apply for is three times your annualized salary or $300,000, whichever is less. Dependent life insurance coverage for your spouse in the amount of $5,000 and for your children in the amount of $5,000 is also available when supplemental coverage is elected. An Accidental Death and Personal Loss double indemnity benefit is provided with employee supplemental life coverage. During your initial new hire/eligibility enrollment or a Qualified Life Event change, you may elect up to the maximum coverage available to you. Thereafter, changes in coverage are restricted to one option level increase at Open Enrollment. Coverage levels automatically adjust for changes in your age and salary.

Refer to the Summary of Coverage for additional information.

***Northern Arizona University***

You pay all premiums for the Aetna life insurance coverage amount that you elect. You may apply for coverage increments of one, two or three times your annual salary rounded to the nearest $1,000. The maximum you may apply for is three times your annual salary or $150,000, whichever is less. Dependent life insurance coverage is also available when supplemental coverage is elected. Option 1 provides $10,000 spouse/$5,000 child(ren) and Option 2 provides $5,000 spouse / $2,500 child(ren). During your initial new hire/eligibility enrollment, you may elect up to the maximum coverage available to you. Thereafter, changes in coverage are restricted to one option level increase at Open Enrollment or a Qualified Life Event change. Coverage levels automatically adjust for changes to your age and salary.

*See the Life Insurance Comparison supplemental page for premiums and plan comparison information.

# SUPPLEMENTAL LIFE INSURANCE COMPARISON

| AGE | THE STANDARD (per $1,000 coverage) | AETNA ABOR & ASU (per $1,000 coverage)* | AETNA NAU (per $1,000 coverage)* | AETNA UA (per $1,000 coverage)* |
|---|---|---|---|---|
| 18-24 | $0.10 | $0.13 | $0.04 | $0.06 |
| 25-29 | $0.10 | $0.15 | $0.05 | $0.06 |
| 30-34 | $0.12 | $0.16 | $0.07 | $0.06 |
| 35-39 | $0.14 | $0.20 | $0.08 | $0.10 |
| 40-44 | $0.24 | $0.23 | $0.09 | $0.16 |
| 45-49 | $0.32 | $0.29 | $0.13 | $0.26 |
| 50-54 | $0.52 | $0.37 | $0.20 | $0.32 |
| 55-59 | $0.74 | $0.48 | $0.30 | $0.50 |
| 60-64 | $1.34 | $0.63 | $0.45 | $0.76 |
| 65-69 | $1.34 | $0.92 | $0.60 | $1.14 |
| Age 70+ | $2.12 | Contact your benefit office for premium rate | | |
| Election Options | Elect in $5,000 increments. Increases may not exceed $20,000 per plan year after initial new hire enrollment. | Option A<br>1x annual salary;<br><br>Option B<br>2x annual salary;<br><br>Option C<br>3x annual salary.<br>Increases may not exceed one step per plan year after initial new hire enrollment. | Option A<br>1x annual salary;<br><br>Option B<br>2x annual salary;<br><br>Option C<br>3x annual salary.<br>Increases may not exceed one step per plan year after initial new hire enrollment, or unless you experience a Qualified Life Event. | Option 1<br>1x annual salary;<br><br>Option 2<br>2x annual salary;<br><br>Option 3<br>3x annual salary<br>Increases may not exceed one step per plan year after initial new hire enrollment, or unless you experience a Qualified Life Event. |
| Minimum Coverage | $5,000 | 1x annual salary rounded up to nearest $1,000 | 1x annual salary rounded to nearest $1,000 | 1x annual salary rounded up to nearest $1,000 |
| Maximum Coverage | $300,000<br>or<br>3 x annual salary, whichever is less | $100,000<br>or<br>3 x annual salary, whichever is less | $150,000<br>or<br>3 x annual salary, whichever is less | $300,000<br>or<br>3 x annual salary, whichever is less |
| Spouse & Dependent Coverage | Mo. Cost<br>$ 2,000 $0.94<br>$ 4,000 $1.88<br>$ 6,000 $2.82<br>$ 12,000 $5.64<br>$ 15,000 $7.06 | Included:<br>$5,000 spouse;<br>$2,500 each child | Option 1<br>$10,000 spouse<br>$5,000 each child;<br>Option 2<br>$5,000 spouse<br>$2,500 each child. | $5,000 spouse<br>$5,000 each child<br>Monthly Cost $0.66 |
| Portability/ Conversion Options | • Conversion Option | Refer to Summary of Coverage | Refer to Summary of Coverage | • Portability and Conversion Option<br>• Retiree Continuation Option |
| Other Features | • Accidental Death & Personal Loss Double Indemnity<br>• Seatbelt Incentive<br>• Non Smoker | • Accidental Death & Personal Loss Double Indemnity | • Accidental Death & Personal Loss Double Indemnity<br>• Waiver of Premium | • Accidental Death & Personal Loss Double Indemnity<br>• Benefit for Total Disability |

* See the Life Insurance Comparison supplemental page for premiums and plan comparison information.

* Coverage levels automatically adjust for changes in salary.

# SHORT TERM DISABILITY (STD) INSURANCE

STD coverage provides replacement income for up to six months if you should become disabled due to a non-work related accident or illness or due to pregnancy. Coverage is available from two companies; you may select one plan and you pay the entire premium on an after-tax basis.

***Standard Insurance Company***
The Standard's STD benefit is up to 66.66% of your base pay with a maximum weekly benefit of $769.27. There are no pre-existing condition limitations, but you must meet the actively-at-work provision on the day before your insurance is effective.

If you elect The Standard's STD for the first time during this Open Enrollment, there is no waiting period for an accident related disability, but there is a 60-day waiting period for benefits to begin for either an illness or pregnancy related disability during the first 12 months of continuous coverage. However, if you were covered by another STD plan for the 12 months prior to October 1, 2007, the 60-day waiting period is reduced to 30 days.

***Unum***
The Unum plan has a waiting period of 30 days for a disability caused by accident, illness, or pregnancy, unless you are hospitalized as an inpatient for at least 24 hours and then you are paid from the first day of disability. Included in this plan is $30,000 Accidental Death and Dismemberment coverage.

If you choose Unum STD as a new hire, you must meet the actively-at-work provision and there is a six-month pre-existing limitation clause that must be met before benefits are paid on pre-existing conditions. If during an Open Enrollment period you already have Unum coverage and elect to increase to a higher option, there is a six-month waiting period for the difference in benefit for a pre-existing condition.

You may choose any one of the three benefit options available, however the maximum weekly benefit this plan pays will always be the lesser of:

- 70 % of your weekly base pay
- $ 750 if you elect Option A
- $1,500 if you elect Option B
- $2,000 if you elect Option C

If you currently have Unum coverage and increase to a higher Option, there is a six-month waiting period for the difference in benefit.

Example:

- Your salary is $200,000 and you have Option A. If you became disabled, your benefit would be the lesser of 70% of your weekly salary ($2,692) or the weekly maximum of

Option A ($750). You would be paid $750.

- At Open Enrollment, you change to Option C.
- Then, if you became disabled, you would be paid either 70% of your weekly salary ($2,692) or the weekly maximum of Option C, $2,000. You would be paid $2,000.
- Therefore, the difference in benefit is $1,250 ($2,000 - $750). It is this difference that you would not be eligible for in the six months after 10-01-2007.

# SHORT TERM DISABILITY INSURANCE COMPARISON

| Unum | Standard Insurance |
|---|---|
| • For non-work related accident or illness<br>• Monthly cost: $0.84 per $100 of salary<br>• After-tax deduction<br>• Benefits are tax-free<br>• Maximum Payment: 26 weeks<br>• Includes $30,000 Accidental Death & Dismemberment Coverage | • For non-work related accident or illness<br>• Monthly cost: $0.87 per $100 of salary<br>• After-tax deduction<br>• Benefits are tax-free<br>• Maximum Payment: 26 weeks |
| • Pays weekly benefit of lesser of:<br>  • 70% of base pay<br>  • $ 750 (Option 1)<br>  • $1,500 (Option 2)<br>  • $2,000 (Option 3) | • Pays weekly benefit the lesser of:<br>  • 66.66% of base pay<br>  • $769.27 |
| • Benefits begin on the first day if hospitalized for at least 24 hours | • Benefits begin on the first day if disability is due to an accident |
| • Benefits begin on the 31st day if not admitted to hospital | • After an Open Enrollment election, benefits begin on the 61st day for illness or childbirth unless you have been covered by another STD plan for the 12 months prior to October 1 |
| • Benefits for pregnancy pay 6 weeks for normal birth, 8 weeks for C-section | • Benefits for pregnancy pay from 31st day through 42nd day after birth |
| • Pre-existing Condition Exclusion for first six months after initial election or after Option level increase | • No Pre-existing Condition Exclusion |
| • Periods of disability due to the same cause count as one period unless separated by six months or more of full-time active work | • Periods of disability due to the same cause count as one period unless separated by 30-days or more |
| • Return to Work: Benefits will stop if working in any capacity | • Return to work: Partial benefits if working 80% or less than full-time |

# LONG-TERM DISABILITY (LTD) INSURANCE

As a retirement-eligible employee, you are automatically enrolled in one of the State's two mandatory LTD programs, starting on your first day of work. The retirement system to which you contribute determines the LTD program available to you.

Your LTD benefit will pay up to 662/3% of your monthly income during your disability. Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits will end as determined by the plan document provisions. Medical documentation of your disability is required to continue your payment of benefits.

If you are facing a possible long term disability, you should contact your Human Resources Office within 60 days from the date of your illness or injury for the information you need to apply for LTD benefits.

**Standard Insurance Company** administers the LTD plan for: the Optional Retirement Plan (ORP), the Public Safety Personnel Retirement System (PSPRS), the Corrections Officer Retirement Plan (CORP), and the Elected Officials' Retirement Plan (EORP).

Note: Medical residents and federal employees not covered by a State of Arizona retirement plan also participate in the The Standard's LTD plan.

**Sedgwick, CMS** (formerly VPA, INC) administers the LTD plan for the Arizona State Retirement System (ASRS). You may learn more about the plan by visiting *www.asrs.state.az.us* or calling 602.240.2009 or 800.621.3788 if outside of Phoenix.

# FLEXIBLE SPENDING ACCOUNTS (FSA)

You have the option to participate in a Health Care or Dependent Care Flexible Spending Account administered by ASI.

- The plan year for FSA is January 1 through December 31.
- Your elections from the prior year do not carry over to the new plan year.
- You must enroll every year.
- University Flexible Spending Accounts Open Enrollment is generally held in November of each year. Elections become effective the following January 1.
- You specify the dollar amount of your earnings to be deposited into each account each pay period.
- The amount is deducted from your check before taxes are taken out, lowering your taxable income and your taxes.
- Throughout the year, after you incur an eligible expense, you submit a claim form and your invoices to ASI for reimbursement.
- You must file claims for expenses that you incurred during the plan year no later than March 31 following the end of the plan year.
- ASI reimburses you from the money you have set aside in your Flexible Spending Accounts.
- ASI offers direct deposit for your reimbursement and email notification of payment.
- You may sign up for direct deposit during FSA Open Enrollment. If you wish to start direct deposit of your reimbursements after the open enrollment period, you will need to do so through ASI. The direct deposit request form is available at www.asiflex.com.
- You may also have your statements sent to you by email. Go to www.asiflex.com and follow the links to sign up.
- Contact ASI if you have questions or problems submitting a claim.

**Use it or Lose it!**
It is important to set aside only as much money in your Flexible Spending Accounts as you intend to use each plan year. IRS regulations require that all money contributed to your Flexible Spending Accounts must be used to pay for expenses incurred (when the services are provided, not when billed or paid) during that plan year only. Otherwise your money is forfeited. Estimate carefully!

Note: When enrolling for a partial Plan year (from your effective date through December 31) remember to include only reimbursable expenses for that period.

**Flexible Spending Accounts Life Events/Mid-Year Changes**
You cannot change your elections to your Health Care or Dependent Care Flexible Spending Accounts after enrollment unless you have a Qualified Life Event as defined by the IRS that causes you, your spouse, or a dependent to gain or lose coverage. The requested change must correspond with the gain or loss of coverage and must be submitted in writing within 31 days of the change.

If you have a Qualified Life Event you may increase or decrease the amount in either or both accounts.

**Tax Credit**

There are additional IRS rules that apply to your Dependent Care Flexible Spending Account contributions. You may be eligible to claim the dependent care tax credit on your Federal income tax return. You may want to consult a tax advisor to determine whether participating in the Dependent Care Flexible Spending Account or taking the dependent care tax credit gives you the greater advantage.

**Using Your Flexible Spending Accounts**

You have several options for obtaining and filing a claim against your Flexible Spending Account. You may obtain a claim form in the following ways:

- On the web - You may download a claim form at www.asiflex.com.
- On the phone - You may call ASI at 1.800.659.3035 and request a claim form.
- By mail - You may request a claim form by sending a written request to: P.O. Box 6 044, Columbia, MO 65205.

You will need to fill out your claim form and attach copies of invoices for services you received. Mail the claim form to the address shown above and wait to receive your reimbursement by direct deposit or check.

# MEDICAL AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

| | MEDICAL CARE | DEPENDENT CARE |
|---|---|---|
| **Maximum Contributions** | $5,000 annually | $5,000 annually ($2,500 if married and filing separately) |
| **Minimum Contributions** | $130 annually | $260 annually |
| **Use of the Account** | * To pay (with pretax money) for health-related expenses that are not covered or only partially covered by your health plans, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans.<br>* To pay for over-the-counter medications that will be used to treat an existing or imminent condition | * Expenses for care of an eligible dependent, that is provided inside or outside your home.<br>* Care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home<br>* Dependent care provided so that you can work |
| **Samples of Eligible Expenses** | * Co-payments<br>* Deductibles<br>* Charges above reasonable and customary limits<br>* Dental fees<br>* Eyeglasses, exam fees, contact lenses and solution, LASIK surgery<br>* Orthodontia<br>* Nonprescription medications (e.g., cold medicines, allergy medicines, antacids, pain relievers) | * Services provided by a day care facility. Must be licensed if the facility cares for six or more children<br>* Babysitting services while you work<br>* Practical nursing care<br>* Preschool |
| **What's Not Covered** | * Premiums for medical or dental plans<br>* Items not eligible for health care tax exemptions by IRS (e.g., cosmetic surgery)<br>* Long-term care expenses | * Private school tuition including kindergarten<br>* Overnight camp expense<br>* Babysitting when you are not working<br>* Transportation and other separately billed charges<br>* Residential nursing home care |
| **Restrictions/Other Information** | * See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at www.asiflex.com for specific details on what expenses are allowed<br>* You cannot transfer money from one account to the other<br>* Your election amount may be increased (but not decreased) if you have a Qualified Life Event | * See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at www.asiflex.com for specific details on what expenses are allowed<br>* You may not use the account to pay your spouse, your child who is under age 19 or a person whom you could claim as a dependent for tax purposes<br>* You cannot change your election unless you have a Qualified Life Event |

# COBRA Continuation of Coverage Notice

Federal law requires that most group health plans give employees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee's spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the State of Arizona group health insurance plans (collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to group health coverage offered by the State of Arizona (the "State") under the Plan (i.e., medical, dental, vision and health care Flexible Spending Account {FSA}) and not to any other benefits offered by the State (such as life insurance, disability, or accidental death and dismemberment). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

**Electing Coverage**
To elect COBRA coverage, you must complete the Election Form according to the directions on the Election Form and mail or deliver the completed form by the date specified on the Election Form to the ADOA Benefits Office as indicated on the Election Form. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverages (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**Electing Health Care Flexible Spending**
COBRA coverage under the Health Care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the Health Care FSA, if elected, will consist of the Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. All qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact the ADOA Benefits Office.

**Special Considerations**
In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the Qualifying Life Event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

**COBRA Duration**
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of a loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- A required premium is not paid in full on time,
- A qualified beneficiary becomes covered after electing COBRA coverage under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied),
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage,
- The State ceases to provide any group health plan for its employees; or
- During a disability extension period (the disability extension is explained on page 40), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA coverage may also be terminated for any reason (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage as in a case of fraud). You must notify the applicable carrier(s) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The claims administrators, insurance carriers and/or HMOs may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

**Extension of COBRA Period**

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage. (The period of COBRA for a Flexible Spending Account cannot be extended beyond the end of the current Plan year under any circumstances.)

**Disability**

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualified. The disability extension is available only if you notify the applicable carrier(s) (see "For More Information" section below) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination
- The date of the covered employee's termination of employment or reduction of hours, or
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- The name and address of the disabled qualified beneficiary
- The date that the qualified beneficiary became disabled
- The date that the Social Security Administration made its determination of disability
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled, and
- The signature, name and contract information of the individual sending the notice

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office (see "For More Information" on page 43).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier(s) of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that

the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

**Second Qualifying Event**
An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the applicable carrier(s) (see "For More Information" section on page 43) in writing of the second qualifying event within 60 days after the date of the second qualifying event.

The notice must include the following information:

- Name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- Nature of the second qualifying event
- Date of the second qualifying event
- Signature, name and contact information of the individual sending the notice

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the ADOA Benefits Office requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice within the required time periods to the ADOA Benefits Office .

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

**COBRA Cost**
Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

**When and How To Pay for Coverage**
If you elect COBRA coverage, you do not have to send any payment with the Election Form.

However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. *ADOA and your vendor will not be able to confirm that you are entitled to covered services until the vendor has received your premium for the month in which the care is to be provided.* (This is the date the Election Form is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery on the Election Form, if hand delivered.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each coverage period for each month for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for these coverage periods (that is, you will receive a bill for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time.

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All COBRA premiums must be paid by check or money order. Payments must be made payable to the applicable carriers for which you are electing coverage:

- UnitedHealthcare for either UHC EPO or UHC PPO
- Fiserv Health - Harrington for any of the following plans: Arizona Foundation PPO, Beech Street PPO, RAN+AMN EPO or Schaller Anderson EPO.
- Delta, MetLife, EDS or Assurant for dental premiums
- Avesis for vision premiums

Your first payment should be mailed to: ADOA Benefits Office 100 N. 15th Avenue, Ste. 103 Phoenix, AZ 85007. After the initial payment, you will receive an invoice each month that will include the applicable Plan Administrator or carrier address.

Note: All COBRA payments for BCBS (NAU only) should be made payable to NAU and mailed to NAU Human Resources PO Box 4113 Flagstaff, AZ 86011-4113.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the university during the covered employee's period of employment is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered employee.

**For More Information**
This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from your Human Resources Office.

**Address Changes**
In order to protect you and your family's rights, it is important that you keep your Human Resources Office informed of any changes in your address and the addresses of family members.

# ADDITIONAL BENEFITS

This information regarding additional benefits is a overview of benefits provided by all three universities. Please reference your individual university's website or consult with your Human Resources Office for the specific policies at your university.

**Supplemental Retirement Savings**
*Tax Sheltered Annuity IRS Tax Code 403(b)*
This type of plan offers the opportunity for you to defer tax on a portion of earnings by purchasing traditional annuity or mutual fund products through the university's approved vendors.

*Deferred Compensation Plan IRS Tax Code 457*
A plan administered by Nationwide Retirement Solutions allowing you to defer a pre-tax portion of earnings into a supplemental retirement account.

**Employee Home and Auto Group Discount Insurance Programs**
Benefit-eligible employees may join a voluntary home and auto group discount insurance program through their university. These programs offer discounted group rates not available to the general public. Other benefits may include:

- Convenient payment options, including direct bill, electronic funds transfer, and payroll deduction
- Customized coverage for your insurance needs
- Money-saving discounts, including multi-policy discounts
- Claims service available 24 hours a day, seven days a week

Please refer to your university's Human Resources website for more detailed information.

**LEAVE POLICIES**
**Bereavement Leave**
You are allowed up to three days of leave for bereavement and funeral purposes of covered family members. For out-of-state funerals the leave increases to five days. You may use sick leave upon the death of family members not covered under the bereavement policy.

**Family and Medical Leave (FML)**
FML provides for up to 12 work weeks of leave during a designated "leave year" for a qualifying reason. You must have at least 12 months of cumulative service and have worked at least 1,250 hours at the university during the 12-month period preceding the date FML is to begin.

FML may apply to continuous, intermittent, or reduced schedule absences. The leave requires the use of accrued sick leave, and permits use of accrued vacation; otherwise, FML is unpaid.

FML qualifying reasons:

- The birth and care of a child;
- The adoption or foster care of a child;
- The care of your spouse, child or parent who has a serious health condition;
- Your own serious health condition that prevents you from performing the essential functions of your position.

**Holiday Pay**

Regular Classified Staff, Service Professionals and Administrative employees shall be granted time off from work with pay for each holiday designated by the university. Ten holidays are normally designated each year.

Employees shall be paid on a prorated basis for designated holidays based upon their regularly scheduled total pay period hours.

**Jury Duty**

Employees called upon for service on a jury or as a subpoenaed witness, other than as a plaintiff or defendant, in a judicial or administrative proceeding, shall be granted leave with pay to perform such service.

An employee who receives a fee for jury duty or as a subpoenaed witness shall either:

- Remit the jury/witness fee to the university and record the time off as administrative paid leave, or
- Accept jury duty fees and record jury duty hours using the appropriate paid or unpaid leave.

**Military Leave**

Employees who are members of the National Guard or a reserve component of the U. S. Armed Forces shall be granted leave with pay for active duty or active duty training for a period not to exceed 30 work days in any two consecutive calendar years.

Employees who are voluntarily or involuntarily placed on extended active duty with the National Guard or the U.S. Armed Forces shall be placed on a leave without pay status in a manner consistent with applicable Arizona Revised Statutes and the Federal Veterans Reemployment Act. Extended active duty is defined as a period of more than 30 calendar days.

**Sick Leave**

Eligible full-time employees accrue sick leave at the rate of 12 days per year; if you are less than full-time, the accrual rate is prorated. Employees accrue and may use sick hours during initial probation. You may be granted sick leave for:

- Personal illness, injury or pregnancy/childbirth
- Obtaining health-related services
- Serious illness/injury within your immediate family or established household.

Sick leave may be accumulated without limitation. Accumulated hours are paid out at retirement (not resignation) according to an established schedule. The Retiree Accumulated Sick Leave program is administered by the State of Arizona GAO. Retirees must qualify and apply for this benefit.

An employee hired from another Tri-U university or a State of Arizona agency within 30 days of termination may have unused accumulated sick leave transferred. An employee rehired by a university within 12 months after termination is credited with all unused sick leave accumulated at the time of termination.

**Unpaid Leaves**
Unpaid leaves of up to one year may be granted by the responsible administrator or supervisor.

**Vacation Leave**
The annual accrual rate for full-time classified staff is:

- First and 2nd years, 11 days per year
- 3rd and 4th years, 16 days per year
- 5th year and beyond, 22 days per year

Vacation hours are accrued on a pay period basis. If you are less than full-time, the accrual rate is prorated.

Administrative, Professional and fiscal-year Faculty employees are entitled to 22 days of vacation each year. Faculty members on academic year appointments are not eligible for vacation leave.

**Qualified In-State Tuition Reduction Program**
The Arizona Board of Regents provides a Qualified Tuition Reduction (QTR) program that enables employees and retirees, their spouses and dependents to enroll in courses of study at reduced registration fees. The QTR is reciprocal among the three state universities and may be used for spring, fall, winter or summer sessions.

**Workers' Compensation**
All employees are insured and are provided benefits under the Workers' Compensation Act in the event of a job-related injury or illness. Benefits include medical expenses, compensation for lost work time, permanent disability benefits and death benefits as applicable.

Absence from work due to an on-the-job injury or illness is considered to be a serious health condition for the purposes of applying Family and Medical Leave. If you are eligible for and entitled to FML, the time away from work while you are covered under Workers' Compensation will be credited to your FML entitlement.

# GLOSSARY OF TERMS

**Actively at Work**
The plan provision that requires you to be performing the duties of your occupation in order for coverage to commence. If you are absent due to illness or injury, the coverage doesn't commence until you return to active work status. You are considered actively at work on a paid vacation day or established holiday if you were actively at work on the preceding scheduled work day. Additional criteria may apply for specific coverage's.

**Coinsurance**
The division of the allowed amount to be paid on a claim, i.e. 70/30 means 70% is to be paid by insurance and 30% is paid by you.

**Coordination of Benefits**
A process used to determine payment of a claim when you are covered under more than one group plan. Benefits under the plans are limited to no more than 100 percent of the claim.

**Co-payment**
The established fee that must be paid to a provider at the time services are rendered.

**Deductible**
The initial amount on a PPO plan you must pay out of pocket before benefits are paid by your insurance.

**Emergency**
Defined by each plan in the Plan Description.

**Exclusive Provider Organization (EPO)**
A prepaid medical group plan that provides a predetermined medical care benefit package.

**In-Network**
Services performed by a provider contracted with a network in accordance with all plan requirements.

**Indemnity Plan**
A health care plan that allows you to choose any licensed provider to receive care. Members are reimbursed for eligible reasonable and customary health care expenses according to the benefits schedule which includes a deductible and coinsurance.

**Medically Necessary**
Services or supplies provided to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field

at the time the patient received the service or in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

**Out-of-Network**
Services performed by a provider that is not contracted with a network.

**Plan Year**
October 1 through September 30 for medical, dental and vision plans. January 1 through December 31 for Flexible Spending Account plans.

**Pre-Existing Condition**
A condition diagnosed and/or treated prior to the effective date of coverage or one for which a prudent person would have been treated.

**Preferred Provider Organization (PPO)**
A plan that allows a member to choose either a provider of their choice or a provider contracted with the network. Choosing an in-network provider will result in a higher percentage of the cost of services being covered.

**Premium**
The amount you and your employer pay for insurance coverage.

**Prescription Drugs**
Any drug or medication that requires a physician order.

**Generic Drug**
A generic drug is one approved by the U.S. Food and Drug Administration (FDA) that is chemically identical to its brand-name equivalent. To win FDA approval, the generic drug must contain the same amounts of the same active ingredients as its brand-name equivalent. A generic drug typically is less expensive and is sold under a generic name for that drug (usually its chemical name). Because generic drugs are less expensive than their brand-name equivalent, your co-payment usually is less, as well.

**Preferred (Formulary) Drug**
All preferred brand drugs have received FDA approval as safe and effective, and have been chosen by a committee of physicians and pharmacists

**Non-Preferred (Non-Formulary) Drug**
A medication that does not appear on the preferred or generic drug list and carries a higher co-payment.

**Reasonable and Customary Charges**
The prevailing charge made by physicians, dentists, or other service providers for a similar procedure in a particular geographic area.

**Self-Insured Plan**
A self-insured plan is one in which the employer assumes the direct financial responsibility for the costs of health insurance claims. Employers sponsoring self-insured plans typically contract with an insurance carrier (i.e. UnitedHealthcare) or third party administrator (i.e. Fiserv Health - Harrington) to provide administrative services.

# NOTICE OF THE ARIZONA BENEFIT OPTIONS PROGRAM PRIVACY PRACTICES

The administrators of Arizona Benefit Options know that the privacy of your personal information is important to you. This Notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this Notice, all references to Arizona Benefit Options refer to the administrators of the Program. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION
Arizona Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. Arizona Benefit Options has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:
To Make or Obtain Payment Arizona Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Arizona Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

**To Conduct Health Care Operations** Arizona Benefit Options may use or disclose health information for its own operations to facilitate the administration of Arizona Benefit Options and as necessary to provide coverage and services to all Arizona Benefit Options' participants. Health care operations include activities such as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Reviews and auditing, including compliance reviews, medical reviews,legal services and

compliance programs.

- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan.

As an example, Arizona Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

**For Treatment Alternatives** Arizona Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health-Related Benefits and Services** Arizona Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

**When Legally Required** Arizona Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

**To Conduct Health Oversight Activities** Arizona Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Arizona Benefit Options, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial and Administrative Proceedings** As permitted or required by state law, Arizona Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Arizona Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes** As permitted or required by state law, Arizona Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Arizona Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

**In The Event of a Serious Threat to Health or Safety** Arizona Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Arizona Benefit Options, in good faith, believes that such disclosure is necessary to prevent or

lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

**For Specified Government Functions** In certain circumstances, federal regulations require Arizona Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

**For Workers Compensation** Arizona Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Other than as stated above, Arizona Benefit Options will not disclose your health information without your written authorization. If you authorize Arizona Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
You have the following rights regarding your health information that Arizona Benefit Options maintains:

**Right to Request Restrictions** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Arizona Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Arizona Benefit Options is not required to agree to your request.

**Right to Receive Confidential Communications** To safeguard the confidentiality of your health information, you may request that Arizona Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Arizona Benefit Options will accommodate reasonable requests, when possible.

**Right to Inspect and Copy Your Health Information** You have the right to inspect and copy your health information. If you request a copy of your health information, Arizona Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

**Right to Amend Your Health Information** If you believe that your health information records are inaccurate or incomplete, you may request that Arizona Benefit Options amend the records. That request may be made as long as the information is maintained by Arizona Benefit Options. Arizona Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created

by Arizona Benefit Options, if the health information you are requesting to amend is not part of Arizona Benefit Options' records, if the health information you with to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

**Right to an Accounting** You have the right to request a list of disclosures of your health information made by Arizona Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Arizona Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Arizona Benefit Options will inform you in advance of the fee, if applicable.

**Right to a Paper Copy of this Notice** You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

DUTIES OF ARIZONA BENEFIT OPTIONS

Arizona Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Arizona Benefit Options is required to abide by the terms of this Notice, which may be amended from time to time. Arizona Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Arizona Benefit Options changes its policies and procedures, Arizona Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Arizona Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Arizona Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

For more information or for further explanation of this document, you may contact an Arizona Benefit Options representative at 602.542.5008 (outside the Phoenix area, toll free at 1.800.304.3687), or by email at beneissues@azdoa.gov. You may also obtain a copy of this Notice at our web site at *www.benefitoptions.az.gov*.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

# 10,000 to 1

## you find the right doctor

ARIZONA FOUNDATION FOR MEDICAL CARE®

**602.251.3236**
**800.624.4277**
**www.azfmc.com**

Arizona Foundation for Medical Care has been providing the community with affordable, quality healthcare since 1969. We have grown to be one of the largest PPO networks in the state with a 38-year commitment to customer satisfaction.

**Comprehensive medical network with multiple plan options**

**Medical Management Services**

---

Our mission is to offer specialized network and healthcare management solutions that fulfill the needs of every client, patient and provider we work with. We remain dedicated to delivering the superior customer service they deserve, and the quality of care they have come to expect.

Viant
HEALTH PAYMENT SOLUTIONS

Beech Street®
A VIANT NETWORK

- Beech Street, a Viant Network has over 50 years of reliable service in the healthcare industry
- Our network consists of over 480,000 respected doctors, 3,800 hospitals and over 44,000 ancillary network providers
- More information about Beech Street can be found at www.beechstreet.com


SCHALLER ANDERSON
HEALTHCARE

State of Arizona employees, now's the time to join the thousands of employees and family members who already put their trust in Schaller Anderson. You'll have access to Arizona providers in more than 23,000 locations, including Mayo Clinic. You'll also participate in one of the least expensive options available.

During open enrollment, choose a company that has been earning Arizona's trust since 1986. Choose Schaller Anderson.

www.schallerandersonhealth.com

Celebrating Excellence 1989 SCHALLER ANDERSON 2009 In Health Care

Benefit Options
Choice. Value. Health.

## State of Arizona Employees:
# Choose health care with a difference.

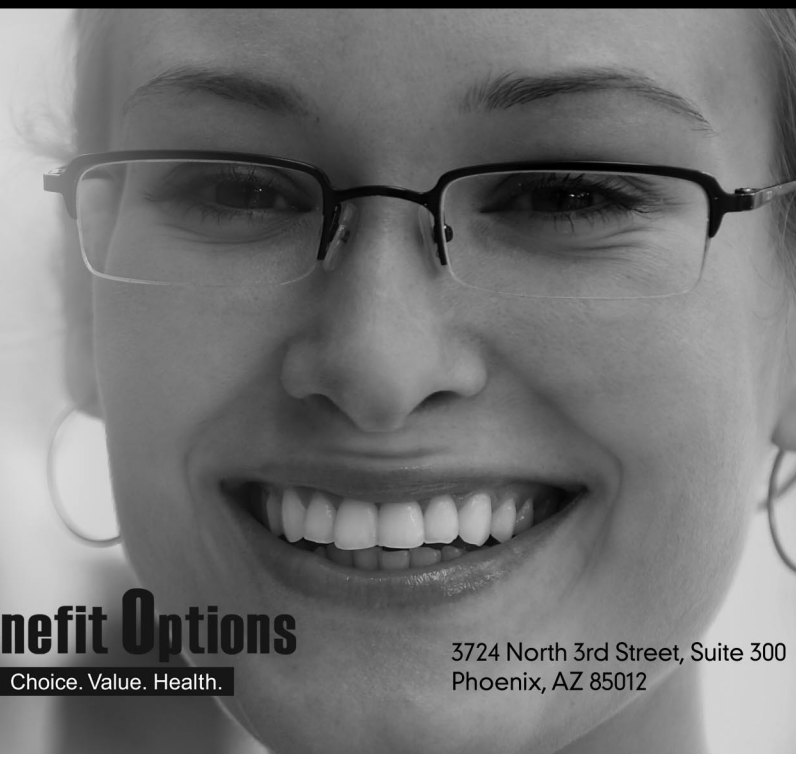
We're committed to making health care simpler and more affordable for our members. When State of Arizona employees sign up for UnitedHealthcare's EPO plan, they get support and services that can help them take charge of their medical care and build a healthier lifestyle.

Our plans also provide access to a nationwide network of 520,000 physicians and 4,700 hospitals, including more than 9,100 physicians and 75 hospitals in Arizona. And with our EPO plan, members can get care from any network physician or network hospital without a referral.

UnitedHealthcare®
Healing health care. Together.℠

unitedhealthcare.com

# VISION CARE
## for Arizona State Employees



Avesis continues to be the State of Arizona's vision care provider for another year. Now is the time to consider your vision coverage for you and your entire family.

With Avesis you will receive a benefit that is easy to use, and provides a tremendous value. Join over 35,000 of your co-workers and enroll with Avesis.

Visit: www.avesis.com/arizona or call 1-800-828-9341

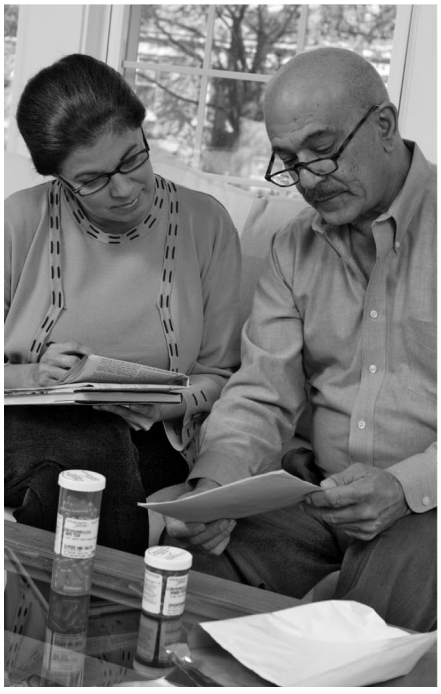
Avēsis
*A National Vision and Dental Company*

**Benefit Options**
Choice. Value. Health.

3724 North 3rd Street, Suite 300
Phoenix, AZ 85012

Walgreens Health Initiatives

## Your Pharmacy Benefit Is Designed to Save You Money



As a member of the State of Arizona Benefit Options' pharmacy benefit plan, administered by Walgreens Health Initiatives, there are two ways for you to save money on your maintenance medications (for long-term conditions).

**1) Walgreens Mail Service = Lower copays**
Save money by paying a lower copay for a 90-day supply instead of three, 30-day supplies at your retail pharmacy. Plus, Walgreens Mail Service is convenient!
- Standard shipping is free
- Orders are shipped right to your door in confidential, tamper-evident packaging
- Three easy ways to order: online, by mail, or by phone

**2) Generic medications = Increased savings**
Copays for generic medications—FDA-approved, chemically identical versions of brand-name medications—are generally less than for brand-name medications.

If you have any questions about using Walgreens Mail Service or generics, please log on to MyWHI.com. You can check copays, find generic alternatives, order mail service refills, and more. Or call our Customer Care Center toll free, 24 hours a day, seven days a week at **866-722-2141.**

ASSURANT
Employee
Benefits

## Assurant Employee Benefits is pleased to offer the State of Arizona the Heritage Plus Prepaid plan

**The Heritage Prepaid plan includes:**

- Fixed copayment schedule for Plan Dentist services
- No claim forms for Plan Dentist and Plan Specialist services
- Each family member may choose a different dentist
- No annual deductible
- No annual maximum for Plan Dentist and Plan Specialist services
- No referral needed to see a Specialist
- An affordable Dental plan option for you and your family

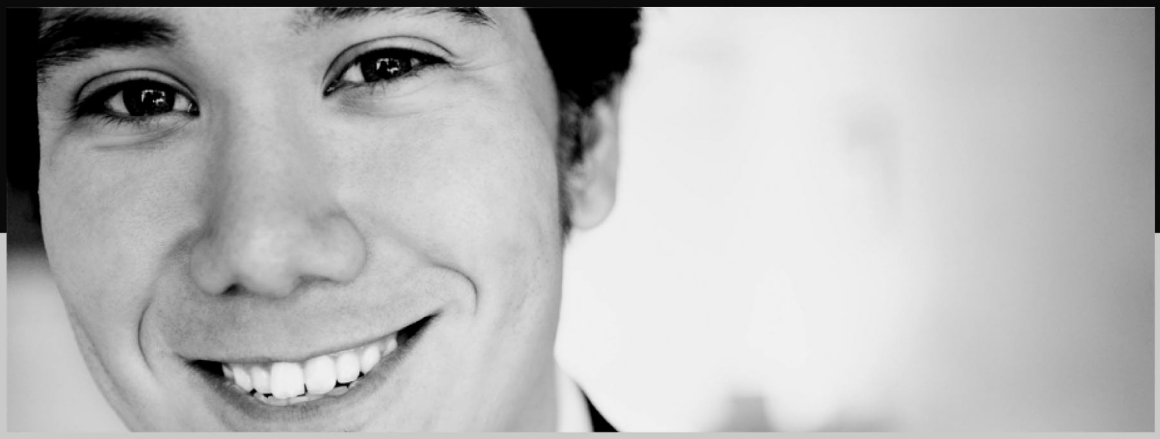
Be sure to review your dental plan options closely.

**Customer Services: 800.443.2995**

Products and services marketed by Assurant Employee Benefits are provided by United Dental Care of Arizona, Inc. Plan limitations and exclusions apply.

WE GIVE ARIZONA'S STATE EMPLOYEES A REASON TO FLASH THEIR

# PEARLY WHITES.



Whether it's Delta Dental's extensive roster of dentists located all over the state, or our friendly, local service with less paperwork, more people choose Delta Dental than any other dental plan. It's no wonder that Arizona's No. 1* dental plan is also the dental plan chosen by more State Employees. Find out what your co-workers are smiling about by visiting **www.deltadentalaz.com.**

DELTA DENTAL®

**Celebrating 35 years of healthy smiles in Arizona.**

*Number 1 according to the 2007 Arizona Woman Who's Who in Business, Ranking Arizona, and Business Journal Book of Lists.*

# Employers Dental Services
## offers a Prepaid Dental Plan to
## State of Arizona Employees

- No Deductibles
- No Claim Forms
- No Yearly Maximums
- No Waiting Period for Major Procedures
- Pre-Existing Conditions Covered (except procedures in progress)
- Customer Service Based in Arizona
- Worldwide Emergency Benefit 24 Hours a Day

### BASIC SERVICES

| | |
|---|---|
| Office Visit | $5.00 |
| Routine Cleaning | $7.00 |
| Amalgam (silver-colored) Fillings | $13.00 - $30.00 |

### ADDITIONAL BENEFITS

- Orthodontic Care for Children & Adults
- Prescription Program
- TMJ Treatment Provided at a Discount
- Specialty Care Provided at a Discount

Employers Dental Services
A company of the Principal Financial Group

For additional information please call Customer Service at: 1-800-722-9772

# Is Your Dental Care Complete?

## Now you can plan for unexpected dental care costs with a dental benefits program from MetLife!

### Now you have more reasons to smile with these valuable features:

**Freedom of choice:** Freedom to visit any dentist whether or not he/she participates in the MetLife Preferred Dentist Program (PDP). Plus, you don't need to pre-select a primary dentist or obtain referrals to see a specialist.

**Broad network access:** Access to a seamless national network of over 100,000 participating MetLife PDP dentist locations including nearly 22,000 specialty locations. And all participating dentists must pass MetLife's rigorous selection criteria.

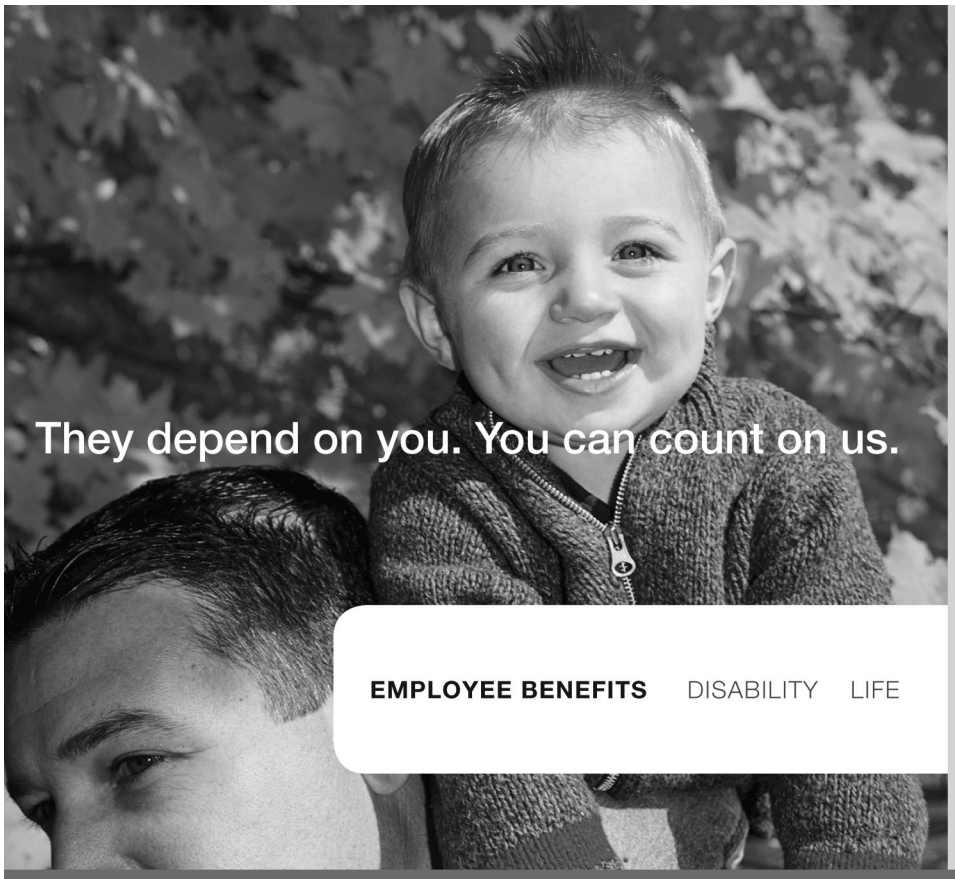
**Lower costs:** Typically save 10% to 35% below the average fees of dentists in your area when you visit one of MetLife's nationwide network of participating dentists who agree to accept scheduled fees as payment-in-full for services rendered.

**Benefits with savings and more value:** Dental coverage with lower costs for covered services as well as non-covered services.* Plus, access to educational tools and resources and pre-treatment estimates — all with service you can trust!

### Join us and see what everyone is smiling about!

*Savings from enrolling in a dental benefits plan will depend on various factors, including how often participants visit the dentist and the cost of services covered.

Metropolitan Life Insurance Company200 Park Avenue, New York, NY 101660707-5280
L07079917(exp0808)(All States)(DC,GU,MP,PR,VI)
Printed in U.S.A.




## LIFE & DISABILITY INSURANCE

For 13 years, Standard Insurance Company has helped State of Arizona employees protect themselves and their loved ones against unexpected loss. Whether you're a current or a new state employee, you can apply for the level of protection that suits you and your family with Additional Life and Voluntary Short Term Disability insurance. At The Standard, we do more than just provide insurance to State of Arizona employees. We help inspire confidence, knowing that someone is there when you need them most.

STANDARD.COM/MYBENEFITS/ARIZONA
866.440.4846

TheStandard®
Positively different.

Standard Insurance Company of Portland, Oregon is licensed in all states except New York. Not all products are available in all states.

## YOU MEAN I CAN USE MY FLEXIBLE SPENDING ACCOUNT (FSA) FOR THAT?


### That's right.

Save up to 40% on items you are already paying for, including glasses, many over-the counter medicines, contact lenses (and solution), many dental expenses prescriptions. Additionally, you can set aside money in the Dependent Care FSA for child care (or in-home care for an older dependent) expenses.

### It's as easy as....

**-1- Deciding how much to set aside -2- Incurring expenses -3- Submitting claims for reimburasement**

## SIGN UP DURING OPEN ENROLLMENT!

### Questions?

Contact ASI with to speak with a Benefits Counselor:

Phone: (800) 659-3035 E-mail: asi@asiflex.com Web: www.asiflex.com

ASI Flex

# EXPERIENCE THE POWER OF CHANGE

MAYO CLINIC | EmbodyHealth
Your Personal Health Management Portal

**Benefit Options**
Choice. Value. Health.

**www.bewellstaywell.az.gov**